Request Follows Hearing on Improper Endoscopic Procedures that put Veterans at Risk of Exposure to Disease

WASHINGTON - Following a hearing that examined substandard endoscopic procedures at Department of Veterans' Affairs (VA) facilities that put more than 10,000 veterans at risk of exposure to disease including HIV and Hepatitis, U.S. Rep. Harry Mitchell has formally requested that the VA Office of Inspector General (VAOIG) conduct a second round of surprise inspections at VA medical facilities to ensure that proper endoscopic procedures are being followed.

"Like most Americans, our veterans count on and expect a great deal of confidence and competency in their medical care," said Mitchell, Chairman of the House Veterans Affairs' Oversight and Investigations Subcommittee. "The VA has a lot of work to do to restore confidence in their system and facilities and it is important that we follow up to make sure that they are now following safe and proper procedures. I look forward to reviewing the results of more inspections."

Mitchell and Subcommittee Ranking Member David Roe (R-TN) sent a letter to VA Inspector General George J. Opfer requesting that VA facilities be examined again within 90 days to ensure that all personnel are following proper endoscopic procedures and VHA directives, including proper reprocessing, correct usage, and correct cleaning of endoscopic equipment.

In May, the Department of Veterans Affairs recommended that more than 10,000 former VA patients who received treatment at three locations get follow-up blood checks due to risk of exposure to disease from improper endoscopies. As of June 17, 53 of these patients have tested positive for HIV or hepatitis virus B or C. [Sources: U.S. Department of Veterans' Affairs, May 27, 2009; The Washington Post, May 30, 2009]

Follow up surprise inspections by the VAOIG found that fewer than half of Veterans Affairs centers they visited last month had proper training and guidelines in place for common endoscopic procedures such as colonoscopies - even after the agency learned that mistakes may have exposed thousands of veterans to HIV and other diseases. [Source: Associated

Press , June, 15, 2009].

During the Oversight and Investigations hearing Mitchell held last week, VA officials apologized for the continuing problems and said directives are being issued to all VA facilities mandating that procedures be followed for maintaining medical devices. Mitchell then indicated that he would like VAOIG to conduct a second round of surprise inspections to ensure the facilities have the proper standards and practices in place. [Source: Gannett, June 17, 2009].